mentally ill patients for dangerousness -- (interrupted)

A. Basically, no. Personally I don't go into that.

Q. Doctor, would you say a patient's history of violence or otherwise dangerous behavior is a relevant criteria in assessing dangerousness?

A. Yes.

Q. How would one gather that kind of information?

A. From the patient. After they receive the patient and get the information, and also from the records. To the extent -- yeah, the records. Either the person used to come to the facility many times or from providers, therapists, psychiatrists, whoever had dealt with the person in the community. Prior hospitalizations.

Q. Okay.

A. Family.

Q. What about a person's criminal record, would you consider that a relevant factor in determining dangerousness?

A. Criminal record is -- first of all, we don't have access to criminal records just like that. Also, I don't see -- I don't see the straight connection unless at some point if there was a criminal behavior and at the same time there was some mental illness involved. I think it would be dangerous for the psychiatrist to go to the legal area and pull issues from the legal area to make a clinical judgment.

Q. Would you agree, Doctor, if a patient had committed a violent criminal act in the past that that would be relevant in assessing that patient for future likelihood of dangerousness?

A. If the person -- at the moment if the person is in the mental health setting and if it was investigated that at the moment when the crime was committed if there was a mental illness involved, but I am afraid to say that because the person has a criminal history and to make the leap straightforward with mental illness and make a clinical decision based on criminal record, I would

not feel comfortable to do that.

Q. When assessing a patient for involuntary commitment, is the patient's criminal record something that you could obtain access to if you wanted to?

A. Criminal record, I'm not aware we can get the criminal record. I'm aware of what we call the rap sheet. It's a kind of -- shows the person's jail history. It means the person was in jail two times, three times and so on, but I am not aware that we can get access to the criminal record. I'm not aware of that. Something we can get is a kind of brief, it's not even a criminal record. When somebody comes to our facility and after being evaluated in jail by two forensic psychiatrists, if they determine that the person should come to our facility under the CPLR 730.40, the person can -- if the person is sent to us from jail, they don't even send you the criminal record, they send just a kind of brief form where the person -- where they mention the crime, the crime and he was evaluated by the

psychiatrist in the records, but in terms of the access to the real criminal record, no, I'm not aware of that.

Q. You said that you do have access to what you refer to as a rap sheet?

A. Yes.

Q. In that rap sheet does it contain information about any time the patient has been arrested and the crime that they have been arrested for?

A. They mention it. They give the term misdemeanor or whatever legal term they use, assault, something like that, but that's it. There's no description of it.

Q. Is that something that you, in your practice, review prior to making the determination that a patient should be involuntarily admitted?

A. No. At that time, no. At that time it's not something we make a determination on. Not all the cases have that. Most of the time we have the person come in from the jail hospital in a pure clinical case. In some cases coming from the emergency room,

so it means there is already enough clinical symptoms for the hospital to make the determination for the patient to come to us, but we are not going to rely primarily or essentially on the criminal record to make a determination. It is available to us, but I think it would be peripheral. That might give us an idea about the person being assertive or aggressive, but still is not the core or essence in our determination.

Q. Would you say that the patient's level of anger is a relevant criteria in assessing danger?

A. Yes.

Q. How would you obtain --

MR. BROUTMAN:

Strike that.

Q. Earlier, Doctor, you mentioned another factor that you considered, substance abuse. In your mind, does it matter that the patient is a present substance abuser as opposed to a past substance abuser?

A. That might play.

Q. How might it play?

A. It plays because some patients they might present with a clinical condition due to intoxication. Some patients might present a clinical condition due to withdrawal. So that's why I say depending if the person is actively using and some symptoms might be related to intoxication or the kind of acute withdrawal. If the person at some point says my last drink or my last -- well, might now be in the frame of protracted withdrawal, it might not be due to the acute effect of the substance, but rather on the withdrawal from the substance. In any case, withdrawal or intoxication, it plays, but will again with the presentation that we have at the moment. If the person is agitated or aggressive due to the intoxication or if person is agitated or aggressive due to the withdrawal. The presentation for us is the same.

Q. Let's say the person was an abuser of substances years prior, but has not used substances at all, let's say, in the past two years up until the time that you are

currently evaluating them for involuntary commitment. Would the fact that they are a prior substance abuser impact your decision whether or not to involuntarily -- (interrupted)

A. It is not enough. We have to rely on the symptom at the moment. The history held to the extent that it might explain the symptoms of the moment, but if they are not connected to the symptom, no.

Q. Do you believe that an individual's family history is a relevant factor in determining whether or not an individual is appropriate for commitment?

A. Family history? No, again, I'm going back again and this is something that I will go over and over. If the symptoms at the moment might have some connection with family history, yes, but family history just for family history, no. Family history means that the -- means that the symptoms that the person has, the person is poor, poor by some means, but it's not enough to make the person seek to the point of

becoming dangerous to self or others. Some other factors have to play.

Q. Let's say we have two patients that present identically. Same symptomatology of mental illness, all factors are the same except that one patient has a family history of suicide and the other patient does not.

A. Okay.

Q. Do you believe that the patient who has a family history of suicide is in any way more likely to cause harm to himself or others than the patient who does not have that family history?

A. That would be, yes.

Q. What about the existence of hallucinations or delusions, is that a factor in making a dangerous assessment?

A. Yes, it is.

Q. Do the kinds of hallucinations or delusions matter in making a dangerous assessment?

A. Yes.

Q. How does it matter?

A. If the person is having common hallucinations, then him or her to kill self

or to kill somebody. If the person has the delusion, acute delusion that the neighbor or the interviewer or the staff in the -- they are there to kill him or kill her, this is one thing, but if the person is having hallucinations where I'm a bad guy, things like that, so the nature of the hallucination plays an important role, but particularly common hallucinations is a very risky one.

Q. Would you agree that if someone were to tell you a particular patient was delusional, but not at all tell you anything else, just that the patient was delusional, that that is not at all helpful in determining whether or not the person is dangerous?

A. I have to assess that myself and try to explore as much as possible the evaluation, the nature of the delusion. Even trying with the patient to see how the person acted when the person who was having the delusion might try hard to have the person tell me -- tell me -- my direct evaluation I might have a sense of what direction that person might

go at the moment. The history might help if the person has a history whenever he or she is delusional and she will have a particular behavior, a pattern. If it is erratic, he or she goes to different behaviors, that will help. I will try hard for my evaluation to see at the moment what the person might do.

Q. So you would say in assessing dangerousness it's relevant to determine if that person has a history of acting on their delusions?

A. Yes.

Q. Would you also agree that it is relevant in assessing dangerousness to know if the patient has a present intent to act on their delusion?

A. That comes in the evaluation, yes.

Q. Would you agree further that a person who does have a present intent to act on their delusions causes a great threat of harm than a person who doesn't intend to act on their delusions?

A. Yes.

Q. How do you go about assessing whether or not

a patient has a present intent to act on their delusions?

A. This is the art of the interviewer. Talking with the patient. First of all the patient has to cooperate. Sometimes there are different ways to ask the question and you have to understand.

Q. For example?

A. The person might not tell you and plan to kill Mr. X, and the patient will not tell you that as soon as I leave here he will kill Mr. X. For many years Mr. X has been on my case, coming to my house, looking at me, it has to stop, something might happen to me.

Q. What about the role of stressors, is that a relevant factor in determining dangerousness?

A. It is, yes.

Q. Family relationships, is that an important factor?

A. Yes.

Q. Employment status?

A. Yes.

Q. Financial stress?

A. Yes.

Q. What about a patient's compliance with treatment?

A. Very important.

Q. Why is that very important?

A. Because it's their ability to rely on treatment.

Q. Talking about -- let's talk about a person being a danger to themselves because they are unable to meet their basic needs. Reaching a conclusion whether or not a person is dangerous to themselves because they are unable to meet their basic needs, do you think it's important to know that a person suffers from malnutrition or dehydration?

A. Yes, it is important. It is important. It might not be an exact point, but yes, it is important. The imminence of the danger is closer because obviously the person is -- if the person or condition is prone to neglect oneself, yes, there's a risk.

Q. Would you say it's important to know whether

or not the person suffers from physical infirmities that have gone untreated?

A. Physical what?

Q. Infirmities that have gone untreated.

A. Yes, it is.

Q. Would you say it's important to know whether or not the person has a willingness to accept treatment?

A. Yes.

Q. Would you say it's important to know whether or not the person has family members that are willing to support the patient?

A. Yes.

Q. Would you say it's important to know whether or not the person is able to obtain and properly store food?

A. Yes.

Q. Would you say it's important to know whether or not the person is able to handle money in such a way that they are able to complete minimal transactions that would acquire them food or clothing?

A. Yes.

Q. Would you say it's important to know whether

or not the person is living in squalor?

A. Squalor? What is that?

Q. Sort of dirty, unhealthy, unkemped living condition, squalor.

A. Yes.

Q. Let's say over the past ten years, all these different risk factors that we have been talking about, were you aware of those risk factors when you have been making determinations to involuntarily commit patients at the time that you were making those decisions?

A. Yes, I'm aware of them. Specifically some patients, not all, every patient will come with full risk, but a particular patient will come with some risk.

Q. Were you aware of that list over the past ten years?

A. Yes.

Q. Before you mentioned 730.40 patients. Do you agree with me those are patients that have been found incompetent to stand trial and are therefore brought to Hudson River?

A. Yes.

second flag. She is anxious, the person in front of me. She is anxious. She is hypertalkative, so it means what we call pressured speech because she keeps talking and talking and talking and talking. The perseverates, she repeats the same thing over and over and over. She has the pressured speech and repeating the same thing. Sometimes you must ask a question, it doesn't matter what you ask for, the person comes with their own idea pushing it all over, the same way. She said several times that she wants to go home, that she wants to be with her mother. The context again, surely it is legitimate for her to be with her mother, but in the context like this I would not expect her going to jail, coming here and to tell me I'm leaving the hospital, I want to be with my mother. I expect her to want to present a case to me, to justify what happened, how she is going to meet with her mother. She says she doesn't like it here because she always spends two hours in the shower every day and

she has to wash to get out of the shower. Now, I have a problem there. Doesn't make sense. If a person feels like taking two hours in the shower, maybe, but I don't expect somebody being evaluated by me telling me okay, I have to spend two hours in the shower, so because I can't do it in your hospital I'm out of here. The judgment is out as far as I'm concerned. Also, two hours in the shower, already we start thinking of obsessive compulsive disorder. This is the thought that we were going to watch for, for somebody to spend two hours in the shower every day you can speculate whatever you want, but immediately this is the sign of obsessive compulsive disorder. Associated with that, the context, if you are in judgment to make a case to tell a psychiatrist that you are not sick enough to be in this hospital, during the evaluation you expect again the person to make a case to you, but not to tell them I'm going home because your hospital doesn't have a shower for me to spend two hours. You have to look

at it how you negotiate with the outside world, where the world is at your service with whatever exaggeration you are in. Essentially, if you are forced by the jail to be in a place like this, you make your case, you convey to the psychiatrist and to the interviewer that everything is flowing. I put denied homicide or suicide at the time of my evaluation. She shows anger and anxiety about being here and some vague delusion about being treated like a dog, the anger, anxiety, pressured speech, perseverates, anger, I come to that conclusion.

Q. When you conduct interviews in order to make a determination of whether a person should be involuntarily committed, do you inform the patient as to the purpose of your interview?

A. Absolutely. I present myself and the reason I talk to the person and to a certain extent I explain the conversion has to be made for the jail status to your status in the hospital, absolutely.

DARYL ROBINSON WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 3 FOR IDENTIFICATION)

Q. Doctor, I'd like to show you Plaintiff's Exhibit 3.

(Document submitted)

A. Okay.

Q. Is this your handwriting?

A. Yes.

Q. Am I correct in saying that this is a certificate that you completed to involuntarily hospitalize this patient?

A. Yes.

Q. Can you read what it is that you wrote in the narrative portion?

A. Let me look it over first.

Q. Sure. I'll ask you to read it out loud for the record.

A. Absolutely. This is a 41-year-old Caucasian male who comes willingly to the interview room. He's cooperative, but not spontaneous in providing information. He answers questions with one or two words. He says

that he was placed in jail after he lit a fire in a driveway in Amenia next to the firehouse. He mentioned that he was cold and he wanted to keep himself warm. He also said that he was at Mercy Hospital, but unable to say why. He doesn't know why he's in this hospital either. His speech is slow, underproductive. He appears to be preoccupied with his inner world. At times he loses contact with the interviewer. He showed some thought blocking. His psychomotor activity is decreased. His mood is flat with blunted affect. His hygiene is fair. His insight and judgment are impaired. The patient is unable to care for himself indefinitely. He is dangerous to himself. He needs inpatient care to stabilize his condition. My signature.

Q. Am I correct in saying that you found this person --

MR. BROUTMAN:

Strike that.

Q. In what way did you find this person, Mr. Robinson, dangerous?

A. The presentation, the person in front of me, how he presents, is he malnourished or not, well kept. Second, he said that he was in jail after he set a fire on the driveway of the firehouse, to go to the driveway of the firehouse to set the fire with the purpose of keeping himself warm. For me, it isn't sound to me in somebody's behavior to set a fire and to lay next to it in the driveway, to me that's not quite okay. Also, he mentioned that he was at Mercy Hospital. Mercy Hospital is a forensic unit. People who go to Mercy Hospital, when they are in jail, if at some point they are in a mental condition that requires treatment, they are sent to Mercy to be studied and then returned to jail. So now we have a combination of jail, we have a combination of hospital.

Q. Let me ask you this, Doctor. Before we talked about different ways which someone can be dangerous. You said a person can be dangerous to others because they might cause injurious behavior, danger to themselves,

might not be able to meet their basic needs, they could be dangerous to themselves or others because their mental illness is so acute that they are unable to navigate the dangers of daily living.

A. Right.

Q. Outside of the ways that I just mentioned, are there any other ways that a person can be dangerous?

MR. PEEPLES:

Objection. Asked and answered.

A. Let me think. It might come to my mind.

MR. BROUTMAN:

Q. All right. Of those ways that we have mentioned that a person can be dangerous, which of those ways was Mr. Robinson dangerous?

A. Again, I said to go to a driveway to set a fire and with his statement that he was cold, he wanted to keep himself warm, what does that mean? He sets a fire, stays, lies down next to it. Do we agree? He sets a fire in the driveway, he sits next to it and lies on the driveway to keep himself warm.

Is that a dangerous behavior? I would say yes.

Q. Now, is that a dangerous behavior because you felt as though Mr. Robinson posed a danger to others?

A. To some extent, yes, but more immediately to himself. Now, if the fire spread, definitely yes, that house would be on fire. We are talking about the second step. Immediately as far as he's concerned, he set the fire and he lies next to it, we are talking about immediate. If we want to speculate a little more, I'll come to that. Didn't go so far and there's a possibility there.

Q. I'm not interested in speculating. I'm interested in what you determine at the time that you completed the certificate.

A. Okay.

Q. So at the time that you completed the certificate, did you determine that Mr. Robinson posed a danger to others?

A. To himself, yes. This is my conclusion. I wrote in my conclusion -- (interrupted)

Q. We will get to danger to others later.

A. No, no. At this point in time my conclusion is clearly he's a danger to himself. At that time if I had any speculation about others, maybe, but now, from what I wrote I cannot extrapolate to come from what I ordered that time. I wrote he's dangerous to himself, he needs inpatient care to stabilize his condition.

Q. Am I correct in saying you concluded Mr. Robinson was a danger to himself and he may have been a danger to others, but at this point in time you were not sure that -- (interrupted)

A. My conclusion from what I wrote, he was a danger to himself.

Q. Did you believe he was a danger to himself because he was unable to meet his basic needs?

A. On a different level. The presentation he was not able to meet his basic needs for him to -- to keep himself warm he chooses the dangerous one, to set the fire in the area on the driveway of a firehouse. Also, his

condition in terms of his judgment he was guided by any means for whatever reason, he didn't want to elaborate on that. He was like I don't want to answer. It means there's no way this person is going to explain or rationalize his behavior. At least by questioning him he would have a chance to give an explanation why he chose to refuse.

Q. Did you believe that Mr. Robinson posed a danger to himself because he might commit suicide or other injurious behavior?

A. Suicide, I didn't mention suicide. If I don't mention it, I can't speculate about it.

Q. What about other self-injurious behavior?

A. I can't speculate. At this point in time, I don't see it or I didn't write it, I don't have any writing as an impression telling me that he was going to cut himself or harm himself.

Q. Okay.

A. I'd like to reinforce one thing, this is somebody I saw at some point. I don't

remember the specifics. When the case is fresh, from the presentation and interview, I might have said something in mind. If I come to the conclusion at the moment the thing I wrote was the salient point for me from the present condition. Other areas, the fire might spread to the house, fine, but the salient point for me to make the decision is, is he dangerous to himself. Two or three years later I can't sit here and tell you. This was in February of '04. This case is not really sharp in my mind now, so to speculate I could not do that. I have to rely on what I wrote at the moment and the presentation I got and put the pieces together, I feel that he was a danger to himself.

Q. Now, although I know you've already testified about this, my question is in what way was he a danger to himself?

A. I say the behavior to set the fire on the driveway, sit next to it, lie next to it to keep himself warm and his inability to cooperate in a sense that he was responding

to inner stimuli. The nature of it I don't know. Was it common hallucination? I don't know. Clearly, it was a responding -- this is a sign of psychosis. He was having problems. This is a disorder. Somebody who is known to engage in the kind of conversation, conversation flow either he has to stop or he just says one way, unable to give his perspective of the situation. This is another thing. Putting everything together from the presentation, from the behavior, from his history, he was at Mercy Hospital knowing what Mercy Hospital is about, clearly Mercy Hospital is a forensic place for people who have medical and psychiatric problems in jail. So luckily if he told me he was at Mercy Hospital that means at some point he was in jail, but because of sickness he has to be treated in a hospital as a prisoner. This is a summary of my evaluation, what you see, talking to himself, not answering questions, thought blocking. Inside his presentation, everything put together, this is how I came

to my conclusion.

Q. Now, focusing on setting fire in the driveway. The fact that this person suffers from a mental illness and sets a fire in the driveway to keep himself warm, does that in and of itself make him dangerous?

A. That's part of the dangerousness. This is a dangerous behavior.

Q. Does that action in and of itself make him appropriate for commitment?

A. I put other pieces in my assessment.

Q. I understand that.

A. It's important for me. It's not just the fire and I come to the conclusion. I was lucky enough at that time to write that situation. I give a description, thought blocking, came from Mercy, his hygiene was fair, he has poor insight, no judgment. That's what we psychiatrists do.

Q. That I understand.

A. I can't follow you then.

Q. Okay.

A. I can't say that he was setting a fire on the driveway of a firehouse and here he is

in the hospital being committed. That's not me.

Q. Would you agree with this, all people that are mentally ill that set fires in driveways to keep themselves warm are not dangerous?

MR. PEEPLES:

Objection to the form.

A. I can't say that. I can't make a speculation about it.

MR. BROUTMAN:

Q. Again, if we gather all of the people that are mentally ill in the world and all of these mentally ill people set fires in driveways to keep themselves warm, is there any number of people within that population that are not dangerous to the point that they are appropriate for the point of commitment?

MR. PEEPLES:

Objection.

A. I can't form an opinion on that. I have to evaluate them.

MR. BROUTMAN:

Q. When evaluating Mr. Robinson, do you know if

he was suffering from hypothermia?

A. I don't know. I don't know if he was suffering from hypothermia, but if it was February, there's no place to stay -- I think it was in February, if he doesn't have a place to stay, I would say it's fair for him to feel cold. I would not go and put a diagnosis of hypothermia while the environment isn't a cold one. Everybody would like to be in a warm place. It's not him having hypothermia. Rather, it was cold weather and he had to be warm.

Q. At the time that you completed this evaluation of Mr. Robinson, would you have been aware as to why he was in Mercy Hospital?

A. If he was cooperative with me, it would be a possibility, yes.

Q. That's not my question. My question is -- my question is would you have been aware from outside sources, not the patient himself, as to why he was in Mercy Hospital?

A. If there was a record at that time, it means when he came to this hospital, if he came

with the worker, that would mention that. If at some point he was a former patient in this hospital, it would have been the possibility. If at the time he was brought to this hospital, he came directly from jail from being arrested for being on that driveway, there was no immediate hospitalization established. I would take some time before getting any workup from Mercy Hospital implying that. He would have to give us another consent or send the consent to Mercy Hospital or any other hospital to get this record. So during the time I did my evaluation, this process necessarily could not be accomplished.

Q. Can you describe what you mean by thought blocking?

A. Thought blocking is when the person has difficulty expressing himself. For example, he would start the sentence, stop, take a pause, and then start again. Or if I ask a question the person has difficulty to make a sentence, will start with I was going -- stop -- take a pause -- and then start

again. Or the person is so limited that the answers are very short, but the person is unable to make a clear sentence to express his idea. In some way this is somebody who needs pauses in expressing himself. Sometimes you get lost because in the pause, the person might not continue the sentence, there is no connection from the previous part.

Q. Am I correct in saying that thought blocking is a symptom of mental illness?

A. Yes.

Q. Do all people that suffer from this symptom of mental illness pose a danger to themselves or others?

A. It's not just that. The thought blocking is one symptom. What we call symptoms, this is part of a syndrome. We admit on the basis of syndrome, so the diagnosis -- the name is the syndrome. The syndrome is what this is, the least of the symptoms. Thought blocking, this is just one symptom as part of a syndrome.

Q. Okay.

A. We meet under the syndrome and the syndrome makes the person -- (interrupted)

Q. Doctor, my question is of all the people that suffer the symptom of thought blocking, are all of them dangerous?

A. I can't answer that. It would be hard for me to take the symptoms and to talk about the decision.

Q. Is it possible that a person who manifests the symptoms of thought blocking is not dangerous?

A. This is a possibility.

Q. Can you tell me how Mr. Robinson's inability to cooperate with your interview is relevant to whether or not he poses a danger to himself or others?

A. The question is too specific. It's part of the whole presentation. If at some point he was exhibiting some dangerous behavior or if he was not able to care for himself from the presentation, but now himself in his ability, this is part of the survival in terms of being able to make his case, able to explain, able to justify, so if he's

unable to do that, either because of his difficulty to express himself, secondary to his illness or if now again he's unable to do that because he's too paranoid, he's too guarded to do that, so clearly there's a problem there. He's able to demonstrate that he does not have the ability to negotiate with the outside world for his own survival, he's a danger to himself then.

Q. Doctor, are all people who are mentally ill and homeless during the winter months in the Poughkeepsie area of New York dangerous to themselves or others?

MR. PEEPLES:

Objection.

A. I can't say that.

MR. BROUTMAN:

Q. Is it possible that someone could be mentally ill and homeless during the winter months in the area of Poughkeepsie and not be dangerous to themselves or others?

MR. PEEPLES:

Objection.

A. I can't answer that question.

MR. BROUTMAN:

Q. Why can't you answer the question?

A. Because it's like taking fragments and other fragments to make a decision. I can't take pieces inconveniently -- I put two pieces together and here I am making a decision.

Q. Can you envision any situation in which a person suffers from a mental illness who is homeless during the winter months in the area of Poughkeepsie and that person is not a threat to themselves or others to cause danger?

A. It's difficult for me to say it that way.

Q. Why?

A. It means in my office or in my general thinking, if a person comes to me, if a person presents in the hospital or if a person has to be evaluated by me, now I'm going to consider all the factors if the person has to stay in the hospital or not. But on the other end, I can't leave the hospital and make speculation out there for who are liable to come to the hospital, I cannot. People come in. I evaluate them to

determine if they should remain in or not. Me, as a psychiatrist, I can't be there in Poughkeepsie assuming that some people should go in. I'm keeping people I feel should be in and sending out people who I feel should be out.

Q. Let's say that the police officers in Poughkeepsie during the winter months round up all of the people who are homeless and living on the streets. And you are examining all of these patients to determine if they should involuntarily be committed. Of those people that are mentally ill, is there -- is it possible that any percentage of those people are not appropriate for commitment?

MR. PEEPLES:

Objection.

A. I can't answer that. Now you pull me in the police business. I can't answer that. If the police arrest them, then I can't answer that.

MR. BROUTMAN:

Q. My question has nothing to do with whether

or not they were appropriately arrested. My question has to do with your evaluation of these group of people who have been presented to you that are homeless in Poughkeepsie during the winter months and who are mentally ill. I'm asking if there is -- if it is possible that any portion of that population of people are not appropriate for commitment?

MR. PEEPLES:

Objection to the form.

A. If I evaluate some of them -- if I evaluate them, if I feel that some of them don't pose a danger to themselves or others, I don't feel they need admission.

MR. BROUTMAN:

Q. Generally speaking, not specifically to Mr. Robinson, when you complete a certificate for involuntary commitment, do you write down all of the ways in which a person is dangerous or just one way seeing how that is sufficient to involuntarily admit the person?

MR. PEEPLES:

Objection to the form.

MR. BROUTMAN:

Q. Nonspecific to Mr. Robinson.

A. This is the way I do it (indicating).

Q. Let me ask you in terms of a hypothetical. Maybe that will make the question more clear. If you are interviewing a patient to determine whether or not they should be involuntarily committed and right off the bat you come to the determination that the person poses a threat of danger to others because, let's say, that person says I'm going to go home and get a gun and shoot so and so. Would you then make the determination as to whether or not they pose a danger in other ways that we have talked about or would your psychiatric conclusion cease at that point because you've satisfactorily reached a condition as to where it would be appropriate to commit that person?

MR. PEEPLES:

Objection to the form.

A. I don't understand.

MR. BROUTMAN:

Q. I understand that was a long-winded question.

A. If the person told me I'm going to get a gun and shoot myself -- (interrupted)

Q. Let's say that happens. Am I correct in saying that you would reach the conclusion that person poses a danger to themselves because they might cause self-injurious behavior?

A. It might be part of it, but I would continue my evaluation. It's part of my red flag. It's part of the whole thing. I'm not going to say this is it, you are committed, but I'm going to continue my evaluation with that element.

Q. Let's say you continue your evaluation and in addition that you conclude that the person poses a danger to themselves because of self-injurious behavior, you also pose an opinion that the person will pose a danger to others and unable to meet their basic needs. In completing the certificate, would you indicate one of those reasons, all three

of those reasons or somewhere in between?

A. I would not spell out specifically. I would examine, of course, indicate where I come from. As you can see in this certificate here (indicating), this is mine, I give a synopsis, and then I don't have to say the person says he's going to take the matches, he's going to get the gas, he's going to buy the gas.

MR. PEEPLES:

Let the record reflect the witness is referring to Exhibit 3.

A. It means the details -- when you do the interview you are lucky enough to get enough element to do the examination. But now in terms of the details, it's more or less luck if you have the patient cooperate with you either because of the illness or because the patient is unable to tell you or the art to get the information, so you have a lot of factors. It means that you can't be fancy in guessing on one as expected. Yes, you are going to set the fire, how did you plan this? Where did you get the gas? You are

quick to get a cross picture of the person in terms of exactly the information I tried to get. If I'm lucky, either of them how you wanted to set the fire and what happened when you went to Mercy Hospital, when you were arrested and in jail, how did you talk to the psychiatrist, all of those kind of things, they are just to put more flesh, so to speak, to different things. I'm lucky I get this form here. If you are somebody who has a third disorder, unable to express self, now to go into details and have the person give you details about one action you lose the person.

MR. BROUTMAN:

Q. Doctor, I'm not concerned with the details. My question is if another psychiatrist were to read your certificates for involuntary commitment, would that other psychiatrist be able to conclude all of the ways in which you believed that that person was dangerous? When I say all the ways in which you believe the person was dangerous, I'm talking about the four different ways in which we talked

about earlier?

MR. PEEPLES:

Objection.

A. That part I can't, because this is the evaluation of the psychiatrist at the moment. In some way I can't put myself in the shoes of another psychiatrist.

MR. BROUTMAN:

Q. My question is if another psychiatrist is reading one of your certificates, would they be able to understand Dr. Paul thought patient X was a danger to himself because he was going to cause self-injurious behavior, and also Dr. Paul thought that patient X was a danger to himself because he was unable to meet his basic needs, would another psychiatrist be able to understand those conclusions based upon reading your certificates?

MR. PEEPLES:

Objection to the form.

A. Again, I can't answer for the psychiatrist. To the best of my ability, I tried to convey that because the patient is dangerous to

himself, he has to be committed. To the best of my ability that's what I put here.

MR. BROUTMAN:

Q. Let's focus on danger to himself. We said there are three different ways that a person can be dangerous to oneself, self-injurious behavior, unable to meet basic needs and unable to navigate the tasks of daily living. In your certificates, do you write them in such a way that another psychiatrist would be able to understand which of those three ways that a person was a danger to himself if you did conclude that the person was a danger to himself?

MR. PEEPLES:

Objection to the form.

MR. BROUTMAN:

Q. I'm speaking generally, not specifically to Mr. Robinson.

A. This is what I presented. If I said you are trying to set fire in the driveway, thought blocking, he was not responding to stimuli, his presentation was unkemp, disheveled, I try to put in as much as I can.

Q. Am I correct in saying that you concluded Mr. Robinson was a danger to himself?

A. Yes.

Q. Did you believe Mr. Robinson was a danger to himself because he had the potential to cause self-injurious behavior?

A. I put unable to care for himself.

Q. Sometimes this is just for clarity of the record, but it's a yes or no kind of question. If you can't answer it -- (interrupted)

A. Could you repeat it again?

Q. Yes. Did you conclude that Mr. Robinson was a danger to himself because he was going to cause self-injurious behavior?

A. I can't answer that. The self-injurious, I can't answer it. The way you ask self-injurious I have it in my mind a certain way. I don't know if this is the way you are asking me.

Q. I want to make sure we are on the same page.

A. Define self-injury.

Q. By that, I mean the person will cause physical harm to themselves, they will cut

themselves, they will shoot themselves, they will do something that will cause physical harm to the body.

A. It directly -- the list you give, no. Secondarily, yes. If he sets the fire and sits next to it or lies down next to it and falls asleep, he can get burned if he falls asleep. I was not saying he was acutely suicidal, where you would go straight, take a knife, cut himself, stab himself, from this writing that was not the impression. Secondarily, either by his inability to provide himself with basic necessities, yes, he was a danger to himself.

Q. Do you know if Mr. Robinson was appropriately able to feed himself?

A. At this point I don't know. I don't remember.

Q. If you concluded that he was unable to appropriately feed himself, was that something that you would have included in the certificate?

A. I would either include it specifically or I would keep it in the -- I would either put

unable to provide himself with food, but usually I don't specifically limit my assessment just to the food. I'm a little bit more general than that. I see larger than just the food. I see food, I see shelter, I see clothing. Navigating the outside world in terms of survival. Food is part of it.

Q. At the time that you evaluated Mr. Robinson, were you aware of the size of the fire that he set?

A. No, I don't have a sense about that.

Q. Were you aware if the fire that he set posed a danger to any other structures in the area?

A. I'm not aware of that.

MR. BROUTMAN:

Mark that.

(CERTIFICATE OF EXAMINING PHYSICIAN, HOLLY RIGGINS WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 4 FOR IDENTIFICATION)

Q. Doctor, is this your handwriting?

(Document submitted)

A. Yes.

Q. Can you read the certificate?

A. Let me read it first. The patient is cooperative in accepting to be interviewed. She said that she was sent to the hospital from Ulster County Jail because she lied to the doctors. She said that she felt suicidal, but she didn't have any plan to hurt herself. The patient is somewhat anxious, hypertalkative and perseverates, P-E-R-S-E-V-E-R-A-T-E-S. She says several times that she wants to go home, that she wants to be with her mother. She says that she does not like it here because she always spends two hours in the shower every day and she has to wash to get out of the shower. She did not have homicidal or suicidal thoughts. She shows anger being here and some vague delusions about being treated like a dog, insight and judgment poor. She needs inpatient care to stabilize her condition.

Q. Doctor, what does the word perseverates mean again?

A. It means doing the same thing again and again independent of any question -- saying the same sentence over and over. I want to go home. I want to go home. I want to go home. I want to go home.

Q. With Miss Riggins, can you tell me in what way she posed either a danger to herself or danger to others?

A. She said she lied to the doctor. Lying, she means -- in some ways that statement for me, what it is she is telling me, is it true or not? For being evaluated before, when she told me she lied to the other doctors, so what would put me in a position to believe what she is telling me is the truth. Also, she says that she feels suicidal. This is a red flag for me. Somebody telling me she felt suicidal, but she didn't have any plan to hurt herself. Yes, she is suicidal, but she doesn't have any plan. Should I rely on that, you are suicidal, you don't have a plan, okay, let's go. Now this is the

A. Others.

Q. If Mr. William had been experiencing these same delusions in the community and had not caused any harm to others, would that then relieve you of your belief that he did, in fact, cause danger to others?

A. Maybe I would not be in a position to evaluate him.

Q. Why do you say that?

A. Circumstances for him to be picked up, to be taken to another hospital and come to the facility would not have been there.

MR. BROUTMAN:

Mark that.

(CERTIFICATE OF EXAMINING PHYSICIAN, MARK TAYLOR WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 6 FOR IDENTIFICATION)

Q. Is this your handwriting?

(Document submitted)

A. Yes.

Q. Could you please read this commitment

certificate?

A. Sure. Patient comes willingly to the room for interview. He mentions that he came from Ulster County Jail and he was treated with Risperdol while he was in jail because of visual hallucinations. He admits that since 1998 he has been experiencing auditory hallucinations. He was hospitalized about thirteen times since then. But he often stopped taking his medication because of drugs. He has used various drugs like LSD, marijuana, cocaine. He mentions that his hallucinations started the same year he began to use drugs. He admits that he has periods where he feels that people are following him or are after him. He admits to having sleeping problems and his appetite is good. He mentions that he used to have short temper in the past, but not anymore. His insight and judgment are impaired and he needs inpatient care to stabilize his condition.

Q. Is it your belief that Mr. Taylor posed a danger to others?

A. Yes.
Q. Is it your belief that Mr. Taylor posed a danger to himself?
A. Not directly, but indirectly.
Q. How indirectly?
A. Because of his behavior. You know, the substance abuse, stop taking the medications.
Q. Does that type of indirect harm to self reach a level of dangerousness where it is appropriate to commit a person?
A. It's not in this case, this particular case, is not the dangerousness to self, but rather the dangerousness to others.
Q. What is it that led you to believe that Mr. Taylor was a danger to others?
A. Number 1, substance abuse. Also he has a mental illness and that can be exacerbated by two factors. Substance abuse can make the illness worse. The noncompliance, the cold turkey stopping of the medication, cold turkey can also cause a sharp decompensation. Also, the other element, short temper. Naturally the insight in

judgment. So poor insight. If at some point he stopped taking medication, both insight and judgment. If he's using drugs, speculation, but there's a possibility that while he's taking psychiatric medication he's also using drugs at the same time which is a very dangerous combination of behaviors.

Q. Was there a particular person that you thought Mr. Taylor was going to harm?

A. For my evaluation, no, there is no specific target. Clearly because of the delusions and hallucination and substance abuse, yes, I believe -- (interrupted)

Q. Do you know what kind of delusions Mr. Taylor was suffering from?

A. People are following me, people being after him.

Q. Did you make any effort to determine whether or not people were actually following him?

A. At this point in time, no. Again, if it is part of the delusion, so it means in the context of my 2 PC, I would have to stop my interview and again go to the extent

possible, and I don't know if it is possible where I am going to look, whom I'm going to call, so it means for the purpose of the 2 PC, if it tells me that he feels that people are following him, or are after him, you know, at the moment just for the purpose of this, I have to go by what he tells me.

Q. Did you ask him who it was that was following him?

A. I don't recall asking him.

Q. Is that something in your general course of your interviews that you would ask?

A. I would ask if I have enough time or if I have the cooperation of the patient. If I can go in details, yes.

Q. Do all mentally ill people who are presently abusing substances pose a danger to others?

MR. PEEPLES:

Objection to the form.

A. I would not see it that way.

MR. BROUTMAN:

Q. What way would you see it?

A. Substance abuse is a high risk of a mentally ill person.

Q. Does it matter what substances they are abusing?

A. Some drugs more than others, but overall substance abuse is a big risk in mentally ill patients.

Q. When you say "some drugs," what drugs?

A. Cocaine, LSD, alcohol.

Q. Those drugs pose the greatest risk?

A. LSD is a hallucinogen. Cocaine is a hard drug. It can go either way, suicide or aggression. So again, all of them -- there are risks with all of them. Depending on the nature of the person, you have to establish the priority.

Q. You say here on the first page since 1998 he's been experiencing auditory hallucinations?

A. Yes.

Q. Do you know what these were?

A. From the purposes of this, I don't remember if he told me. If he told me, then I would have put it down.

Q. Would it be helpful to know what those auditory hallucinations were in order to

gather information and you have a sense of where the person comes from. Again, the physical examination, yes, to some extent can be helpful, but on the reverse the physical examination is not just a conduit as soon as you feel that the person is having a medical problem and you make a straight connection whether the person cares for himself.

MR. BROUTMAN:

Mark that.

(CERTIFICATE OF EXAMINING PHYSICIAN, SIMON BENEPE WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 8 FOR IDENTIFICATION)

Q. Doctor, is that your handwriting?

(Document submitted)

A. Yes.

Q. Can you read the certificate?

A. Patient comes willingly to the room for the interview. Initially he appears suspicious and guarded. On two occasions he asks the

writer for his title and work location. When the patient feels a little bit more comfortable, he begins to talk continuously. His speech is pressured. His thinking process is circumstantial and illogical. He presents some looseness of association. Thought content shows moderate delusion. His insight and judgment are impaired. He mentioned that he was in this facility on two or three occasions and his peers worked it out for him to leave. The patient was presenting a danger to himself and others. He needs inpatient care to stabilize his condition.

Q. Focusing on your conclusion that he posed a danger to others, what led you to believe that he posed a danger to others?

A. He is delusional and he has thought disorder and his speech is pressured and -- mostly he's delusional and guardedness.

Q. What type of delusions did he suffer from?

A. I don't have a specific cite here. I don't describe the specifics.

MR. BROUTMAN:

likely cause harm in the future?

A. Yes.

Q. Am I correct in saying that if he had not acted on his delusions in such a way to cause harm to people in the past he would be less likely to cause harm in the future than if he had acted that way in the past?

A. Yes, there's a possibility.

MR. BROUTMAN:

Mark that.

(CERTIFICATE OF EXAMINING PHYSICIAN, RICHARD BACON WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 10 FOR IDENTIFICATION)

Q. Doctor, Plaintiff's Exhibit 10, is this your handwriting?

(Document submitted)

A. Yes.

Q. Read that in the record.

A. This is a 59-year-old Caucasian male with a history of alcohol abuse, admitted to this facility by transfer from Ulster County Jail

after the charges of criminal trespass, harassment were dismissed due to his mental condition. The patient had said to come to the interview room and is cooperating. While he's answering all the questions, he appears to be on the defensive saying repeatedly that he does not steal and does not panhandle. He says several times that somebody who looks like him and dresses exactly like him used to go and panhandle, steal and give his name. He admits that the situation has been going on for four years. He does not give any answer when asked if he was arrested before. When asked about his living situation, he says that he holds, H-O-L-D-S, an antique shop, that he buys, fixes and resells antiques. He appears to confabulate when asked specific questions and he goes back to issues of somebody using his name to steal and panhandle. He's more oriented to person, but partially oriented to place and time. He knows only month and year. He is casually dressed, fair hygiene, not as depressed with blunted affect. When

asked about feelings of depression, he pauses for a few seconds and says it's better now. He didn't want to elaborate on his feelings before. His insight and judgment appear impaired and needs inpatient treatment to stabilize his condition.

Q. Was it your belief Mr. Bacon posed a danger to others?

A. To self.

Q. Did Mr. Bacon pose a danger to himself because of potentially self-injurious behavior?

A. He doesn't appear to be self-injurious, but his inability to not care for himself in part. When I write this, I had the impression that he was depressed.

Q. Are all depressed people unable to care for themselves?

MR. PEEPLES:

Objection to the form.

A. I would not put it that way.

MR. BROUTMAN:

Q. How would you put it?

A. If when somebody is in the hospital and is

evaluated for depression, the psychiatrist will do other factors to determine if the person was a danger to self.

Q. What factors would a psychiatrist look at?

A. Not only depression, but also the ability to care for self. It means all the factors associated with the depression, no energy, the act to go and navigate naturally because the person can be so depressed, confined in one corner and doesn't do anything. Means doesn't have the energy to go and deal with the day by day life. Naturally other factors, self-esteem.

Q. What about Mr. Bacon's depression led you to believe that he was unable to care for himself?

A. Mr. Bacon's -- I think there is some element of psychosis in Mr. Bacon. Aside from my feeling at that time that he was depressed, as I said, not as depressed, but with blunted affect. Now if he was around begging, asking people for whatever he was asking for, and at some point there is nothing wrong with that, so clearly there is

something with the judgment that is not quite there. There is an impaired judgment in terms of the self-care. Also, as I pointed out, the confabulation, it means I asked him a question, he will create something just to give me an answer. He has that shop that he holds, something like that, he says he's -- obviously there is nothing in his condition to confirm that by any means. At that point I could not really establish that.

Q. By that you are talking about whether or not he actually owned this antique shop?

A. Right.

Q. Is that what you talking about?

A. Right. In fact, if -- I have to look again, but I think he was arrested for going to an antique shop. I don't remember this, but he was arrested for trespass.

MR. BROUTMAN:

Let's mark his psychiatric evaluation.

(PSYCHIATRIC EVALUATION, RICHARD BACON WAS RECEIVED AND MARKED AS PLAINTIFF'S

complete.

Q. So then we should probably forget this document and move onto the next one.

MR. BROUTMAN:

Mark this.

(CERTIFICATE OF EXAMINING PHYSICIAN, ROBERT BURLEIGH WAS RECEIVED AND MARKED AS PLAINTIFF'S EXHIBIT 13 FOR IDENTIFICATION)

Q. Doctor, is this your handwriting?

(Document submitted)

A. Yes.

Q. Can you identify this document?

A. Yes.

Q. What is that?

A. Certificate of Examining Physician.

Q. Before you start reading it, Doctor, let me ask you a quick question. When evaluating a patient for a 2 PC commitment, how is it that you come to be aware that this patient needs to be evaluated?

A. The ward clerk calls me. There's a clerk

that the person should not be admitted, it's now up to the ward physician and the team to make the next step for the person -- I might not know exactly what happened, so it means after I give the paper to the clerk it becomes part of the record, but now the final decision is the team, treatment team decision. If they decide to discharge a person, they call the crisis residence, they call the families, whatever the disposition is.

Q. If you examine a patient for involuntarily commitment and you determine that the person is not appropriate for involuntary commitment, do you still complete the certificate?

A. Yes. I would have to complete this part of the status of the patient.

Q. So you complete the certificate regardless if your conclusion is to involuntarily commit or not involuntarily commit?

A. Right. This is part of the record. When the person comes from jail, the person has to get his status in the hospital. When the

person -- the person cannot be somebody physically in this hospital with the 730.40 status. It's not a hospital status.

Q. Moving specific to Mr. Burleigh.

A. The patient comes willingly to the interview room. He appears tired and he ambulates at a slow pace. His hygiene was poor. He was superficially cooperative at the beginning of the interview, raising his shoulder for some questions and saying I don't know for some others. He then cooperates. There's a missing part here.

Q. All right.

A. Goes along. He admits to having received psychiatric treatment before, but is not aware of the treatment and the diagnosis. He remembers that he received the medication that started with P. He said that the police arrested him while he was walking down the street to go visit his family. He mentioned that life has been difficult for him for the last six years after he broke up with his girlfriend and he has not been able to find a steady job. The place he was

working at for ten years went out of business. His parents died and his siblings are scattered all over the country. For eight months he has lived here and there with friends up to two months. They were not able to help him any further. Since then he has been homeless. He's alert, oriented to place, person, but not to time. He is disheveled with poor hygiene. Sad, depressed with blunted affect. His thinking process is underproductive, but goal directed. His thought content does not show delusions. He denied auditory hallucinations. He denied suicidal thoughts. His insight and judgment are poor. He expresses hopelessness and helplessness. He admits to sleeping problems, but denies problems with his appetite. He needs admission to stabilize his condition.

Q. Did Mr. Burleigh pose a danger to himself because of his ability to self-injurious behavior?

A. Inability to care for self. In my writing I

don't have -- I don't have it here that he's suicidal, but because of his condition his inability to care for himself is the reason.

Q. I've noticed at the beginning of a lot of these certificates you indicate that the patient is willing -- the patient comes willingly to the interview room. Is there a reason that you write that in the certificate?

A. This is my style, to give a flavor of the patient in terms of cooperating. It happens that sometimes you go to a patient and they say leave me alone, I don't want to talk to you. It might take some convincing techniques, some talk, something to have the patient cooperate a little bit for one. Also, it happens in some cases the patient might say no, I'm not going to talk to you, so I have to sit exactly where the patient is to try to get some information. It means that the person is not going to move from point A to go into an interview and sit with me quietly and talk. This already gives the writer who is in the clinical field a flavor

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.): Bacon Richard

Sex: Male Date of Birth: 5/14/47

Address: HPPC 35

CERTIFICATION

I, _____, hereby certify that:
(Name of Examining Physician)

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 09 (MO.) 22 (DAY) 03 (YEAR) at Hudson River Psychiatric Center
(place where examined)
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs).*
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

PENGAD 800-631-6989 PLAINTIFF'S EXHIBIT 10 6/29/06

Signature	Print Name Signed	Title
E Paul MD	FRANCK PAUL	PSYCHIATRIST
Address	**Phone Number**	**Date** (Mo / Day / Yr) / **Time** (Hr / Min / AM PM)
10 Ross Circle Poughk NY 12601	(845) 483-3192	09 / 22 / 03 — 11 : 00 AM

This is a 54 y.o Caucasian male with a history of alcohol abuse admitted to this facility by transfer from Ulster County Jail after the charges of criminal trespass harassment 1 were dismissed due to his mental condition. The patient accepts

HR 05 010

Person's Name (Last, First, M.I.)

to come to the interview room and he is cooperative. While he is answering all the questions, he appears to be on the defensive saying repeatedly that he does not steal and does not pedhandle. He says several times that somebody who looks like him and dresses exactly like him used to go and pedhandle, steal and gave his name. He admits that the situation has been going on for 4 years. He does not give any answer when asked if he was arrested before. When asked about his living situation he says that he holds an antique shop, that he buys, fixes and resells antiques. He appears to confabulate when asked specific questions and he goes back to the issue of somebody using his name to steal and pedhandle. He is well oriented to person but partially oriented to place and time (he knows only month and year). He is casually dressed with fair hygiene. His mood is depressed with blunted affect. When asked about feelings of depression, he pauses for a few seconds and says: "It's better now." He does not want to elaborate on his feelings before. His insight and judgment appear impaired. He needs inpatient treatment to stabilize his condition.

F Sandberg

HR 05 011

OMH 471A (2-94)

State of New York
Office of Mental Health

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.): BURLEIGH, Robert

Sex: M Date of Birth: 1/13/71

Address:

CERTIFICATION

I, FRANCK PAUL (Name of Examining Physician), hereby certify that:

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 11 (MO.) 23 (DAY) 04 (YEAR) at Hudson River Psychiatric Center (place where examined).
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs)*.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

PENGAD 800-631-6989 PLAINTIFF'S EXHIBIT 13 PD 6/29/06

OMH PHI HR 05 129

Signature	Print Name Signed	Title
F. Paul MD	FRANCK PAUL	PSYCHIATRIST

Address	Phone Number	Date (Mo. / Day / Yr.)	Time (Hr. / Min. / AM/PM)
10 Ross Circle Poughkeepsie NY 12601	(845) 483-3192	11 / 23 / 04	11 / 00 / AM

The patient comes willingly to the interview room. He appears tired but he ambulates at a slow pace. His hygiene is poor. He was superficially cooperative at the beginning of the interview, raising his shoulders for some questions or saying "I don't know" for some others. He then cooperates [illegible] education. He admits to have received psy-

Form OMH 471A (2-94) page 2

Person's Name (Last, First, M.I.)

Form G

chiatric treatment before but he is not aware of the treatment and the diagnosis. He remembers that he received a medication that started with "P." He says that the police arrested him while he was walking down the street to go and visit his family. He mentions that life has been difficult for him for the last 6 years after he broke up with his girlfriend and he has not been able to find a steady job. The place he was working at for 10 years went out of business. His parents died and his siblings are scattered all over the country. For 8 months, he has lived here and there with friends up to 2 months when they were not able to help him any further. Since then, he has been homeless. He is alert, oriented to place, person, not to time. He is disheveled with poor hygiene. His mood is sad, depressed with blunted affect. His thinking process is underproductive but goal directed. His thought content does not show delusions. He denies auditory hallucinations. He denies homicidal or suicidal thoughts. His insight and judgment are poor. He expresses hopelessness and helplessness. He admits to sleeping problems but denies problems with his appetite. He presents a danger to himself. He needs inpatient care to stabilize his condition.

HR 05 130

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.): ROBINSON Daryl

Sex: M Date of Birth: 05/08/61

Address:

CERTIFICATION

I, FRANCK PAUL, MD (Name of Examining Physician), hereby certify that:

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 02 (MO.) 10 (DAY) 04 (YEAR) at Hudson River Psychiatric Center (place where examined).
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs)*.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

PLAINTIFF'S EXHIBIT 3 6/25/08 PENGAD 800-631-6989

HR 05 0172

Signature	Print Name Signed	Title
F Franck MD	FRANCK PAUL	PSYCHIATRIST
Address	**Phone Number**	**Date** (Mo. / Day / Yr.) **Time** (Hr. / Min. / AM / PM)
10 Ross Circle Poughkeepsie NY 12601	(845) 483-5192	02 / 10 / 04 — 3 / 45 / AM (PM)

This is a 41 year old Caucasian male who comes willingly to the interview room. He is cooperative but not spontaneous in providing information. He answers questions with one or two words. He says that he was placed in jail after he lit a fire on a driveway in America next to the fire hose. He mentions that he was cold and he wanted to keep himself warm. He also

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	Person's Name (Last, First, M.I.)

says that he was at Mercy Hospital but unable to say why. He does not know why he is in this hospital either. His speech is slow, unproductive. He appears to be preoccupied with his inner world. At times, he loses contact with the interviewer. He shows some thought blocking. His psychomotor activity is decreased. His mood is flat with blunted affect. His hygiene is fair. His insight and judgment are impaired. The patient is unable to care for himself independently. He is dangerous to himself. He needs inpatient care to stabilize his condition. F Panel wg

HR 05 073

Form OMR 471A (2-94)

State of New York
Office of Mental Health

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.): Berger Simon 106 00

Sex: M Date of Birth: 10/14/66

Address:

CERTIFICATION

I, FRANCK PAUL (Name of Examining Physician), hereby certify that:

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 05 (MO.) 20 (DAY) 05 (YEAR) at Hudson River Psychiatric Center (place where examined).
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs)*.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

HR 05 206

PLAINTIFF'S EXHIBIT 8 6/29/06 PENGAD 800-631-6989

Signature	Print Name Signed	Title
F. Paul MD	FRANCK PAUL	PSYCHIATRIST
Address	**Phone Number**	**Date** (Mo / Day / Yr) / **Time** (Hr / Min / AM PM)
10 Ross Circle Poughkeepsie 12601	483-3192	05 / 20 / 05 — 12 / 30 — AM PM

The patient comes willingly to the room for the interview. He readily appears suspicious and guarded. On 2 occasions, he asks the writer for his title and work location. When the patient feels a little bit more comfortable, he begins to talk spontaneously. His speech is tense. His thinking process is circumstantial and

Person's Name (Last, First, M.I.)

illogical. He presents some looseness of associations. Thought content shows moderate delusions. His insight and judgment are impaired. He mentions that he was in this facility on 2 or 3 occasions and his peers worked it out for him to leave. The patient represents a danger to himself and others. He needs inpatient care to stabilize his condition.

Form OMH 471A (2-94)

State of New York
Office of Mental Health

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.) Taylor Mark 104040

Sex M Date of Birth

Address HCR 35

CERTIFICATION

I, FRANCK PAUL, MD, hereby certify that:
(Name of Examining Physician)

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 04 (MO.) 25 (DAY) 05 (YEAR) at Hudson River Psychiatric Center.
(place where examined)
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs)*.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

PENGAD 800-631-6989
PLAINTIFF'S EXHIBIT
6
DD 6/29/06

OMH PHI

HR 05 192

Signature	Print Name Signed	Title					
F. Paul MD	FRANCK PAUL	PSYCHIATRIST					
Address	Phone Number	Date			Time		
10 Ross Circle. Poughkeepsie 12601	(845) 483-3192	04 Mo.	25 Day	05 Yr.	1 Hr.	30 Min	AM (PM)

The patient comes willingly to the room for interview. He mentions that he came from Ulster county jail and he was treated with risperdal while he was in jail because of visual hallucinations. He admits that since 1998 he has been experiencing auditory hallucinations. He was hospitalized about 13 times since then. But he often stopped taking

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Person's Name (Last, First, M.I.)

his medications because of drugs. He has used various drugs like LSD, marijuana, cocaine. He mentions that his hallucinations started the same year he began to use drugs. He admits that he has periods where he feels that people are following him or are after him. He admits to having sleeping problems and his appetite is good. He mentions that he used to have short temper in the past but not anymore. His insight and judgment are impaired. He needs inpatient care to stabilize his condition.

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